STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN46573

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00087506. Complaint number IN00087506 substantiated Federal/State deficiency related to the allegation is cited at F282. Survey dates: April 10, 11, 12, 13, 14, 2011 Facility number: 000521 Provider number: 155582 Aim number: 100266980 Survey team: Carol Miller RN, TC Mavis Stob RN Ellen Ruppel RN Census bed type: SNF: 16 SNF/NF: 103 Total: 119 Census payor type: Medicare: 16 Medicaid: 82 Other: 21 Total: 119 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Please accept this written POC as our credible allegation of compliance. The facility respectfully requests paper compliance for the two citations included in the 2567.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 4-15-11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. Based on interviews and record review, the facility failed to ensure the physician's orders for anticoagulant therapy was either initiated or discontinued for 1 of 7 residents receiving anticoagulant therapy in a sample of 24. Resident C 2. Based on review of records and interviews, the facility failed to ensure the outpatient dialysis service agreement was followed in regard to care and treatment for 1 of 1 resident receiving outpatient dialysis treatment in a sample of 24 . (Resident #51) Findings include: 1. The closed clinical record of Resident C was reviewed, on 4/11/11 at 9:30 a.m., and indicated the resident had been admitted to the facility 11/24/10, discharged home on 1/13/11 and then readmitted to the facility on 1/18/11. The resident's diagnoses included, but were	F0282	It is the policy of Miller's Merry Manor, Wakarusa to provide/arrange for services to be delivered by qualified person's and to ensure care is provided as indicated in each residents individual plan of care.Resident C: Discharged from facility 1/31/2011Resident #51: Discharged from facility on 4/14/2011All Residents are at risk to be affected by the deficient practice.The dialysis agreement was reviewed by the nurse management team on 4/14/2011. The unit managers or other designee reviewed all resident charts for those who are receiving outside dialysis services on 4/14/2011 to ensure that the outlined services agreement is being followed and delivered per each individual resident's health care plan. An all nursing in-service will be held on or before 5/13/2011 to review the facility policy for "Dialysis Care" and to review the outside dialysis services agreeement. The charge nurses will utilize a communication tool that is to be sent to and from the dialysis unit	05/13/2011

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	not limited to: coronary artery disease, dysphagia, chronic obstructive pulmonary disease and prosthetic aortic and mitral heart valves. The readmission orders, on 1/18/11, included an order for aspirin 81 mg. daily. The order had not been transcribed from the hospital admission orders to the facility medication sheet and the resident had not been given the aspirin as ordered. Review of the Medication Administration Record (MAR), for the month of January 2011, indicated the resident had "missed" 12 doses of aspirin. She had also been on varying doses of Coumadin (a blood thinner) determined by the results of the clotting time of the blood. Resident C was sent back to the hospital, on 1/31/11, due to an acute cerebrovascular accident. During an interview and medication order review, with the Corporate Nurse, on 4/12/11 at 2:00 p.m., she indicated the order for the aspirin had been "missed" when the resident returned to the facility on 1/18/11.		on days of treatment. Pertinent assessment findings will continue to be communicated to the dialysis unit per the outlined services agreement.The unit managers and or other designee will complete an in-house audit of all physician orders by 4/30/2011 to ensure medications are being administered as prescribed/ordered by the physician. An all nursing in-service will be held on or before 5/13/2011 to review the facility policy of taking, transcribing, and noting physician orders. For new admissions and readmissions the charge nurses will be instructed that all admission orders will require that two nurses review and sign off as complete and accurate to ensure that orders are transcribed correctly. The unit manager or other designee routinely review new admission charts/readmission charts to monitor that orders are transcribed accurately. The medical records designee is responsible to complete a "Admission/ReAdmission Tool" within approx. 72hours after admission.*The QA tool titled " Dialysis Review" will be completed by the unit manager or other designee 3x weekly for the next 4 weeks then monthly thereafter to monitor for ongoing compliance. The QA tool titled "Admission/Readmission Review"*	

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	2. The clinical record of Resident #51 was reviewed on 4/13/11 at 10:00 A.M., and indicated diagnoses which included, but were not limited to, repair of fractured hip and renal failure with dialysis. Documentation in the Nurses progress notes, dated 12/26/10 (Sunday) at 10:02 A.M., indicated "Resident...c/o (complained of) bruise left upper arm. Dark purple bruise noted to left upper arm, measure 15 CM (centimeters) x 12 CM. Left upper arm warm and tender touch. Left arm swollen from elbow to upper arm...." The next documentation, dated 12/26/10 at 10:04 A.M., indicated " (name) dialysis notified of resident condition. Nurse on call, stated "resident had a large infiltrate on Friday during dialysis. This size of bruising is normal."...." Review of the Agreement signed by the dialysis center and the facility and dated January 1,1999, indicated under responsibility of the care provider section C "Participate in interdisciplinary dialysis team conferences...." and under section D "Maintain appropriate documentation of services provided by the nephrology Inc staff and to provide the same to Nephrology, Inc upon request."		*will be completed per medical records or other designee within 72 hours following each admission to ensure that physician orders are transcribed correctly. Any identified problems will immediately be clarified with physician and reviewed to ensure accuracy of physician orders. The facility will document any findings on a QA summary log and review during the facility monthly QA meeting.*	

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	On 4/13/11 at 3:00 P.M., the unit director was interviewed in regard to the procedure for receiving information from the dialysis center following each treatment in regard to any laboratory tests being done there and any incidents which may have happened during the treatment. The unit director provided a note book with documentation written by the Unit Director and dated from March 2011 to present. There was no documentation provided by the dialysis center. The unit director further indicated the facility never received any communication from the dialysis center and did not participate in care plans with the dialysis center. This Federal tag relates to Complaint IN00087506 3.1-35(g) 3.1-35(g)(2)			
F0508 SS=D	The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on review of records and interview, the facility failed to ensure a diagnostic test report was filed in the clinical record in regard to a venous doppler test for 1 of 4 Residents reviewed for x-rays and diagnostic tests, in a sample of 24. (Resident #112)	F0508	It is the policy of Miller's Merry Manor, Wakarusa to provide and obtain radiology and other diagnostic services to meet the needs of its residents and will be responsible to ensure the quality and timeliness of the services.Res#112: The diagnostic test results for the	05/13/2011

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	Findings include: The clinical record of Resident #112 was reviewed on 4/12/11 at 1:40 P.M., and indicated diagnoses which included but were not limited to pulmonary hypertension and stasis dermatitis. There was a physician's order, dated 1/12/11, for a venous doppler test to be done along with other laboratory tests in regard to a rash on the resident's legs. There was no report of the result of the doppler test in the clinical record. When interviewed on 4/13/11 at 9:30 A.M., the DNS (Director of Nursing Services) indicated the doppler test had been done on 2/10/11, and the report had been given verbally to the unit director. At this time, the DNS provided a copy of the venous doppler report, dated 2/10/11. The report was marked as being faxed to the facility on 4/12/11 at 4:53 P.M. 3.1-49(g)		venous doppler test were obtained and placed on the residents chart on 4/13/2011. Future results of diagnostic testing for resident will be obtained promptly and placed in the resident chart and maintained per facility medical records policy.All residents are at risk to be affected by the deficient practice.All resident charts were audited by the nurse management team on 4/14/2011. All diagnostic tests have been completed as ordered and the appropriate computed/written results of the diagnostic test is included in the individual resident chart to comply with the regulation and facility medical record policy. The process that each charge nurse shall follow to ensure that diagnostic test results are promptly included in each residents individual EMR will be shared during an all nursing staff in-service on or before 5/13/2011. It will be the responsibility of the charge nurse to document in each individual residents EMR when a diagnostic test has been ordered and the arrangments for getting the test completed. Upon completion of the ordered diagnostic testing the charge nurse will be responsible to contact the provider for a report of the findings. Charge nurses will be instructed to request a written report from the outside provider on the day diagnostic testing is completed and daily thereafter	

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			until a copy of the report is received. Any initial verbal report of findings will be included in the EMR progress notes. The charge nurses will be instructed to document completion of diagnostic testing on 24hour report tool and to continue to indicate on 24 hour report tool that facility is awaiting results each shift for the following 72hours until results are received. The IDT routinely reviews the 24hour report tool and will be able to follow the status of the ordered diagnostic test to its completion and ensuring that written results are made available promptly on resident charts. The QA audit tool entitled "24hour report" will be completed by the facility unit managers or other designee 3x weekly for 4 weeks, then weekly x4weeks, then monthly thereafter to monitor for ongoing compliance. Any identified trends/issues with obtaining written results within 72hours of completion of diagnostic testing will be reported to DON and logged on a facility QA tracking log. The facility QA tracking logs will be reviewed during the monthly facility QA meeting to ensure ongoing compliance.	